State of California—Health and Human Services Agency

Department of Health Services
Radiologic Health Branch
P.O. Box 942732, MS 178
Sacramento, CA 94234-7320

REGISTRATION TO OFFER NUCLEAR MEDICINE TECHNOLOGY CONTINUING EDUCATION COURSES

Name	Daytime telephone number ( ) ext.

Mailing address (number, street)	City	State	ZIP code

Type

☐ Professional organizations ☐ Technologist ☐ Hospital ☐ Physicist

☐ Professional society ☐ Physician ☐ Other (please specify) _____

1. List CE coordinator or instructor's name, title, and major duties._____

_____

2. Professional certification. List boards, category, and year certified._____

_____

3. Education. List academic degree(s), major and minor._____

_____

4. List professional journals you receive. _____

_____

5. List academic appointments. (Use additional sheets if more space is needed.) _____

_____

6. List publications you have authored or coauthored. (Use additional sheets if more space is needed.) _____

_____

Specify the continuing education courses to be offered:

☐ Diagnostic in vivo and in vitro tests involving measurement of uptake, dilution, or excretion, including venipuncture, but not involving imaging.

☐ Diagnostic nuclear medicine technology procedures involving imaging, including venipuncture.

☐ Use of generators and kits for preparation of radioactive material.

☐ Internal radioactive material therapy.

Indicate nuclear medicine technology continuing education course(s) offered in the past. (Use additional sheets if more space is needed.)

_____

Specify the continuing education courses to be offered. ☐ Brochure attached

☐ Brochure not attached (please explain) _____

_____

DECLARATION

I certify that the information provided on this document and submitted with this document is true and accurate.

Signature	Date

FOR DEPARTMENT OF HEALTH SERVICES USE ONLY

Registration number	Approved by	Date

Mail to: Department of Health Services
Radiologic Health Branch
Attn: Certification—NMT
P.O. Box 942833, MS 178
Sacramento, CA 94234-2833